No. 93-1251

In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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TABLE OF AUTHORITIES

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1. Respondent attempts to defend the court of appeals' broad holding that the Secretary's regulations require application of generally accepted accounting principles (GAAP) to resolve every reimbursement issue, in the absence of a specific regulation to the contrary with respect to a particular issue. See Br. in Opp. 12-21. As we explain in the certiorari petition (Pet. 14-22), however, nothing in the text or background of the pertinent regulations supports that rule. The purpose of the reimbursement principles set forth in the Secretary's Provider Reimbursement Manual[1] (PRM) (including PRM Section 233, which addresses advance refunding transactions) is to

[1] United States Department of Health & Human Services, Health Care Financing Administration, Medicare Provider Reimbursement Manual (1987).

resolve reimbursement disputes arising under those longstanding regulations. The very existence of (and pervasive reliance on) the PRM in the day-to-day administration of the Medicare Program demonstrates the fallacy of respondent's and the court of appeals' view that the Secretary has effectively delegated to the accounting profession the power to prescribe and revise reimbursement principles, and thereby to dictate the outcome of reimbursement disputes under the massive and costly Medicare program.[2] See Pet. 15.

If the Secretary had intended that GAAP would trump even express provisions of the PRM, surely the regulations or the PRM itself would have said so. In fact, however, the foreword to the PRM states (at I) that GAAP should normally be applied in determining reimbursable costs *where the Secretary's guidelines and policies do not supply a contrary rule*. See also *American Medical Int'l, Inc.* v. *Secretary of HEW*, 466 F. Supp. 605, 624 n.21 (D.D.C. 1979). Moreover, the Commissioner of Social Security formally explained the operation of the regulatory scheme in this manner in 1976 when he promulgated certain reimbursement rules relating to equity capital, stating (41 Fed. Reg. 46,292 (emphasis added)):

> [G]enerally accepted accounting principles are applicable to Medicare cost determinations only when a cost situation is not covered by 20 C.F.R. Part 405 [now 42 C.F.R. Part 413] *or the Provider Reimbursement Manual*. It is only in the absence of health insurance program policy that generally accepted accounting principles should be followed.

[2] The Medicare regulations were promulgated before the accounting profession had adopted an exclusive GAAP standard for accounting for advance refunding transactions. See *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26 (APB 26) ¶¶ 4-10 (Accounting Principles Bd. 1972) (describing alternate methods in general use before adoption of exclusive method by APB 26). Respondent's thesis must therefore be that although the Secretary's method of accounting for such transactions was permissible under her regulations at the time they were issued, it ceased to be permissible at the moment the Accounting Principles Board promulgated APB 26. See Br. in Opp. 17 n.6.

That reasonable interpretation of the Secretary's own regulations is entitled to "controlling weight."[3] See *Stinson* v. *United States*, 113 S. Ct. 1913, 1919 (1993).

2. In the alternative, respondent attempts to defend the court of appeals' decision by asserting that the longstanding regulatory scheme implementing the Medicare program distinguishes for present purposes between *whether* and *when* particular costs incurred by a provider will be reimbursed. In respondent's view, the regulations do not require use of GAAP in determining whether costs will be reimbursed, but generally do require use of GAAP with respect to timing. The regulations on which respondent relies draw no such distinction. They speak only of "[s]tandardized * * * accounting * * * and reporting practices," 42 C.F.R. 413.20(a), and of "the accrual basis of accounting," 42 C.F.R. 413.24(a). If, as respondent claims, those regulations require the Secretary to apply GAAP in determining Medicare reimbursements, they provide no basis for her to distinguish, in doing so, between "characterization" and "timing" issues.

Moreover, even a proper cost of care is "allowable" under Medicare only with respect to the particular period

[3] Respondent cites (Br. in Opp. 18) a court's passing characterization of the Secretary's position in *HCA Health Services of Midwest, Inc.* v. *Bowen*, 869 F.2d 1179, 1181 (9th Cir. 1989), for the proposition that the Secretary has switched her position depending on which interpretation of the regulations helped her cause in particular litigation. That is incorrect. The Secretary has never disputed that GAAP provides standard accounting rules that may be useful in determining proper Medicare reimbursement (as well as for general recordkeeping and financial reporting purposes) where the regulations and the PRM do not prescribe a particular rule. So far as we are aware, however, the Secretary has never taken the position that her regulations require application of GAAP for reimbursement purposes where, as here, she *has* prescribed a contrary interpretation. We have reviewed the government's brief in *HCA*, and it is fully consistent with that position.

in which the provider rendered the care to which the cost relates; and the determination of *when* a cost relates to the provision of patient care is as fundamental as the determination of whether it relates to patient care at all.[4] See generally 42 C.F.R. 413.9 (cost determination); 413.24(d) and (f), 413.50, 413.53 (apportionment); 413.60(b), 413.64(b) (estimated and final payments); see also *Research Medical Center* v. *Schweiker*, 684 F.2d 599, 603 (8th Cir. 1982) (deferring to PRM capitalization requirement for interest on construction loans because spreading costs over several years best reflects benefit of constructed facility to Medicare beneficiaries). Medicare reimbursement is made on an annual basis, following review of the provider's annual cost report. See *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. 2151, 2157 (1993); *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 400-401 (1988). It is based on "the actual cost of services furnished to beneficiaries *during the year*." 42 C.F.R. 413.9(b) (emphasis added). Accordingly, the central issue in reviewing a provider's report is what costs may properly be reimbursed by Medicare *for that cost year*. The reason why costs might not be reimbursable for the particular cost year has no bearing on whether the Secretary is obligated to look outside her own policy directives under the Medicare Program—to GAAP—in order to resolve that issue.

3. Respondent repeatedly refers to "the accrual basis of accounting" as though that term were synonymous with GAAP. See, *e.g.*, Br. in Opp. 14, 16, 20-21. It is not. Both as a matter of normal usage and as defined in the relevant regulation itself, accrual accounting describes any system under which "revenue is reported in the period when it is

[4] Indeed, as pointed out in the petition, the apportionment of a provider's otherwise allowable costs between Medicare and non-Medicare patients may vary substantially from period to period (because, for example, of fluctuations in the provider's patient mix). Shifting such costs between periods may therefore have an equally substantial effect on the amount that is actually *reimbursable* under Medicare. See Pet. 21, 26 n.15.

earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." 42 C.F.R. 413.24(b)(2). That definition is broad, and excludes primarily "cash-basis" accounting, under which revenues are reported when collected, and expenses when paid.

Respondent's bald assertion that "[t]here are no 'versions' of accrual accounting" (Br. in Opp. 17) is simply wrong. "Cost" or "management" accounting, for example —that is, accounting that is designed to provide current and often specialized financial information for management purposes—is generally based on accrual principles, but is not governed by GAAP. See generally D. Keller, J. Bulloch & R. Shultis, *Management Accountants' Handbook* 1.2-1.3 (4th ed. 1992). Accrual (*not* cash-basis, compare Br. in Opp. 20-21) accounting for state and local governments and their proprietary activities may be governed by the standards of the Governmental Accounting Standards Board (GASB), which differs from the GAAP applicable to private entities—but which in fact *constitutes* "GAAP" for those entities to which it applies.[5] See generally R. Kay & D. Searfoss, *Handbook of Accounting and Auditing* 31-4 to 31-10 (2d ed. 1989); M. Dittenhofer, *Applying Government Accounting Principles* § 1.03[2] (1990) ("only the standards promulgated by the GASB have the status of GAAP for state and local governments"); *id.* at §§ 9.03-9.04 (discussing "accrual" and "modified accrual" accounting); A. Afterman & R. Jones, *Governmental Accounting and Auditing Disclosure Manual* § 1 (1992). And in areas where a particular GAAP standard has not been established, or where GAAP recognizes more than one approach, a variety of quite different approaches may be recognized as legitimate

[5] As noted in the petition (at 18 n.11), the GASB's Statement of Governmental Accounting Standards No. 23 requires covered entities to report gains and losses on advance refunding transactions on a deferred basis very similar to that required by the Secretary for purposes of Medicare reimbursement.

methods of accrual-basis accounting. See, *e.g.*, APB 26, ¶¶ 4-10; see also note 2, *supra*. Thus, even if the regulations' requirement that providers keep financial data "on the accrual basis of accounting" (42 C.F.R. 413.24(a)) were interpreted to constrain the Secretary's discretion in making use of those data in determining appropriate Medicare reimbursements, it could not be read to require her to defer specifically to GAAP in making those determinations.[6]

4. Respondent argues (Br. in Opp. 17-18) that the "cost finding" provisions of 42 C.F.R. 413.24 demonstrate that the same Section's references to "the accrual basis of accounting" apply to the Secretary's reimbursement determinations, rather than simply to the way in which a provider's records must be maintained. The "cost finding" required by the regulations refers to the process of apportioning general and indirect costs (such as many administrative costs) to recognized cost centers for purposes of Medicare reimbursement. See generally 42 C.F.R. 413.24(d). That process merely requires the provider to reorganize some of its normal financial data in a way specifically designed to help identify which of its costs for the relevant period—all of which are presumably

[6] Respondent's defense of the court of appeals' holding that PRM Section 233, which prescribes non-GAAP treatment for advance refunding gains and losses, is a "substantive" rather than an "interpretative" rule (Br. in Opp. 21-24) makes clear that the argument rests entirely on the proposition that the Medicare regulations require application of GAAP in the absence of a specific statute or regulation to the contrary. Respondent's argument (Br. in Opp. 24) based on 42 U.S.C. 1395hh(a)(2) rests on the same proposition—that PRM Section 233 "changes a substantive legal standard governing * * * the payment for services," because (in respondent's view) the general regulations "establish, as a baseline, that reimbursement determinations will be made in accordance with GAAP. Both arguments thus depend in turn on the equation that respondent posits between GAAP and "the accrual basis of accounting" within the meaning of 42 C.F.R. 413.24(a). See, *e.g.*, Br. in Opp. 21, 23. As discussed above and in the petition, however, that equation is fallacious.

legitimate under GAAP—are allowable under the special standards of the Medicare program. If the requirement that providers "recast" their basic financial data in that way in preparing their Medicare cost reports has any larger significance, it is to refute respondent's simplistic assertion (Br. in Opp. 15) that section 413.20(a) of the regulations somehow guarantees that in order to be entitled to reimbursement, providers need do no more than present the Secretary with their "basic accounts, as usually maintained."[7]

5. a. The court of appeals' erroneous ruling warrants review by this Court. In attempting to distinguish the conflicting cases cited in the petition (Pet. 11-14), respondent contends that those decisions "address whether or not a certain type of cost is allowable" (Br. in Opp. 9), and accuses the Secretary of "confus[ing] the issue of cost allowability with the issue of the timing of reimbursement for allowable costs." *Id.* at 8. It is of course true that in

[7] Respondent also notes (Br. in Opp. 14) that the certiorari petition does not discuss 42 C.F.R. 413.5(b)(1). The court below did not cite that Section in support of its holding, and it is without relevance. Section 413.5(b)(1) states a general principle of current payment for expenses as they are incurred, which is implemented by specific interim payment and retroactive adjustment provisions. See 42 C.F.R. 413.60, 413.64; *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. at 2155-2156. It has nothing to do with determining when expenses are incurred (a central question of accrual accounting), so that "current payment" becomes appropriate. Indeed, read in isolation, the "current payment" language would suggest a rule of cash-basis reimbursement —that is, payment shortly after the provider is forced to "put up money for the purchase of goods and services." 42 C.F.R. 413.5(b)(1). As respondent itself points out, however, the cash outlays relevant to this case took place primarily in 1972 and 1982. Br. in Opp. 4. Respondent and the Secretary agree that Medicare reimbursement with respect to those cash expenditures is appropriately spread out over many years after they took place. The only question at the time of refunding is whether the original costs that remain unrecovered (as well as certain costs of the refunding itself) should continue to be recognized on the original schedule, or be accelerated into the year of the refunding. Section 413.5(b)(1) provides no guidance on that question.

most advance refunding cases, including this one, there is no dispute as to the overall refunding loss (or gain) realized by a Medicare provider; the question is, instead, in which accounting period or periods that loss should be taken into account (or "allowed") for purposes of Medicare reimbursement. See Pet. 25. As we have just explained (see pages 3-5, *supra*), however, there is no relevant distinction between that question of "timing" and the question of "reimbursability *vel non*" (Br. in Opp. 10 (citation omitted)). Both are aspects of the same question presented by this case: whether the Secretary's regulations require that a provider's costs be reimbursed in all respects—including timing—in accordance with GAAP.

In any event, respondent's attempt to deny the existence of a circuit conflict on the basis of its timing/allowability distinction is unconvincing. To begin with, there was no dispute in *Methodist Hospital of Indiana, Inc.* v. *United States*, 626 F.2d 823 (Ct. Cl. 1980) (see Br. in Opp. 9) that the pension costs at issue in that case were both (i) reimbursable if properly accrued and (ii) properly accrued for purposes of the provider's financial accounting. 626 F.2d at 824, 826. The decision stands cleanly for the proposition that the Secretary need not defer to a financial accounting determination of the proper *timing* of an otherwise reimbursable cost.

Similarly, the issue in *Richey Manor, Inc.* v. *Schweiker*, 684 F.2d 130 (D.C. Cir. 1982), was whether a stock purchase should be treated as a purchase of assets for Medicare purposes, thus allowing the purchaser to allocate the stock price to the assets and recover it over time through increased depreciation. Although the court disposed of the case on other grounds, it made clear that even if the transaction were properly characterized as an asset acquisition for accounting purposes, that would not determine the proper Medicare treatment. *Id.* at 135. And the issue of accounting or reimbursement "symmetry" on

which that conclusion turned was as much one of "timing" as one of "reimbursability *vel non*."[8]

To be sure, some cases holding that GAAP does not automatically govern the Secretary's reimbursement decisions deal with issues of characterization, rather than timing. The courts in *National Medical Enterprises, Inc.* v. *Sullivan*, 916 F.2d 542, 547 (9th Cir. 1990), cert. denied, 500 U.S. 917 (1991), and *Sun Towers, Inc.* v. *Heckler*, 725 F.2d 315, 328-329 (5th Cir.), cert. denied, 469 U.S. 823 (1984), rejected the contention that because "stock maintenance" costs were recognized as legitimate administrative expenses under GAAP, the Secretary was required to treat them as reimbursable costs of patient care. As explained above, however, the regulations on which respondent relies draw no distinction between "characterization" and "timing" issues, and that distinction therefore cannot detract from the conflict that exists over whether the regulations require the use of GAAP in resolving reimbursement questions.[9]

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[8] As the court explained, allowing the buyer's accounting treatment to dictate reimbursement would "destroy the symmetry of the regulatory scheme" by allowing increased depreciation deductions to the buyer in years after the purchase, without a corresponding recapture, in the year of the sale, of depreciation deductions previously taken by the seller. 684 F.2d at 135. The fundamental point is to allow only one reimbursement for the original cost of the assets, either by denying duplicative depreciation deductions (and corresponding cost reimbursements) to the buyer, or by balancing such future deductions (and reimbursements) against a lump-sum recapture amount recognized as income to the seller in the year of the sale. Either system must be followed with respect to both buyer and seller in order to achieve proper overall timing of depreciation reimbursements for the acquired assets. The court indicated that it would defer to the Secretary's resolution of that "timing" issue for Medicare reimbursement purposes, without regard to the accounting treatment adopted by either party to the transaction. *Ibid.* & n.5.

[9] A panel of the Fifth Circuit recently accepted the distinction of *Sun Towers* proposed by respondent in this case, and reversed a decision in favor of the Secretary on the advance refunding issue. *Mother Frances Hosp.* v. *Shalala*, No. 93-4388 (5th Cir. Mar. 3, 1994),

b. Respondent does not seriously attempt to refute our submission (Pet. 24-27) that this case presents an issue of substantial practical and legal importance. Indeed, respondent concedes (Br. in Opp. 25) that the petition "conclusively demonstrates" the importance of the issue to providers—and, by the same token, to the Secretary. Beyond that concession, respondent merely restates the premise that Section 233 of the PRM works a substantive change in reimbursement rules established by the general Medicare regulations, and on that basis argues that the decision below is unremarkable in requiring compliance with the notice-and-comment requirements of the Administrative Procedure Act. Br. in Opp. 25-26. It is precisely by adopting that false premise, however, that the court of appeals has threatened both normal principles of deference to the Secretary's interpretation of her own regulations implementing a complex benefits program, and the imposition of substantial unjustified monetary liability on the federal government. As set forth in the petition, those threats warrant review by this Court, especially in view of the continuing circuit conflict on the basic question presented.

For the foregoing reasons and those stated in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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slip op. 2838-2839; compare Pet. 14 n.9. We obviously disagree with the panel's reading of *Sun Towers*, as well as with its decision on the merits. We also note that respondent's reliance (Br. in Opp. 10-11, 16) on decisions of the Provider Reimbursement Review Board is misplaced. Each of the Board's advance refunding decisions has been reversed by the Secretary's designate; and it is the Secretary, not the Board, to whose expertise deference is due. *E.g.*, *Sun Towers*, 725 F.2d at 326; *St. Francis Hosp. Ctr.* v. *Heckler*, 714 F.2d 872, 874 (7th Cir. 1983); cf. *Martin* v. *OSHRC*, 499 U.S. 144, 152-153 (1991).